STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00107210 completed on 5/1/12. Complaint IN00107210 - Corrected. Unrelated deficiency cited. Survey dates: June 18 and 19, 2012 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 61 Residential: 26 Total: 87 Census payor type: Medicare: 9 Medicaid: 43 Other: 35 Total: 87 Sample: 7 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Landmark Nursing and Rehabilitation Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 6/22/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure residents receiving anticoagulant medication were monitored to ensure the necessity of the medication in the dose ordered for 2 of 4 residents reviewed related to anticoagulant medications in a sample of 7 residents. (Residents C and H) Resident C's coagulation times were not monitored, and he was hospitalized for diagnoses including rectal bleeding and Coumadin toxicity.	F0329	F**329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** I. Resident C no longer resides in facility. Resident H has been assessed for any negative outcomes related to Coumadin therapy. The Physician has discontinued Coumadin order for Resident H on June 22, 2012, related to post-surgical utilization. II. All residents receiving Coumadin were reviewed, including PT/INR orders, antibiotic orders and	07/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The clinical record for Resident C was reviewed on 6/18/12 at 1:50 p.m. The record indicated the resident was admitted to the facility on 5/8/12 after hospitalization. The hospital physician's Progress Notes, dated 5/8/12, included, but were not limited to "[arrow pointing up - increase] Coumadin." The hospital "Discharge/Transfer Medication Reconciliation Report, dated as printed 5/7/11 at 11:05 p.m., included, but was not limited to, Coumadin [anticoagulant] 4 mg by mouth daily, with a start date of 5/7/12. A line was drawn through the 4, and above the 4 was handwritten a 5. The report also included Keflex [antibiotic] 500 mg by mouth every 6 hours for 7 days, with a start date of 5/8/12. The hospital Discharge Summary, dictated 5/8/12, typed 5/8/12, and authenticated by the physician on 5/10/12 included, "...Clinical course: [name of resident]...was sent in here because of generalized weakness and was found to have increasing redness and cellulitis of his right leg. He had a hematoma at this site from trauma while on Coumadin and he was taken off of Coumadin, I believe, two months ago and then had an I&D [incision and drainage]done on the leg for		current medications. The Physician was notified for all Residents receiving Coumadin. III. The Management of Coumadin Therapy Policy has been reviewed and revised. The policy was reviewed and the revision was approved by the Medical Director. A Coumadin/Medication Alert was created, reviewed and approved by the Medical Director. The Coumadin/Medication Alert was completed for each Resident, and will continue to be completed for any new applicable Resident. The Coumadin/Medication Alert was placed in each Resident's Medical Record that is receiving Coumadin located in front of the Physician order section. All nurses will be in-serviced on the revised Management of Coumadin Therapy Policy and the new Coumadin/Medication Alert system by July 2, 2012. IV. A Coumadin Management Audit Tool was created and will be utilized, daily, to review PT/INR results, Coumadin dosage, frequency of labs and follow-up lab date on an on-going basis. The Coumadin Management Audit Tool will review PT/INR results, Coumadin dosage, frequency of labs and follow-up lab date. This audit will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hematoma....Cardiology was consulted because of anticoagulation issues, and [name of cardiologist] felt strongly that he ought to be back on Coumadin. Therefore, this was gradually restarted. His INR [International Normalized Ratio - measurement related to clotting time] slowly edged up to 1.4, but will need to be monitored closely, and Coumadin dose needs to be adjusted until INR is between 2 -3 and regulated...." The note indicated the resident would be discharged to the facility for follow-up with the physician there. Physician's orders upon admission on 5/8/12, included, but were not limited to, Baby Aspirin [antiplatelet] 81 mg, one by mouth daily; Keflex 500 mg, one by mouth daily; and Coumadin 5 mg, one by mouth at 4:00 p.m. The orders also indicated PT/INR [Protime/International Normalized Ratio] due 5/10/12. On 5/9/12, a physician's order was received for "Flagyl [antifungal for treatment of C. difficile diarrhea] 500 mg, one by mouth 3 times daily for 10 days."		be completed on all Residents with current Coumadin orders. The DON, ADON and/or designee will continue to audit those residents receiving Coumadin daily for 2 weeks, weekly for 2 weeks, monthly for 2 months and then quarterly. The Director of Nursing or designee will review all new orders to identify new antibiotic orders and proper follow through. The Director of Nursing will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. Any areas of concern will be addressed, immediately. Audits will be reviewed by the QA committee on a monthly basis to ensure compliance. V. Date of Completion: July 2, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Medication Administration Record indicated the resident received the following medications as indicated on the admission orders from 5/9/12 through 5/19/12: Coumadin, aspirin, Flagyl, and Keflex. The Medication Administration Record indicated the resident received Norco 4 times daily from 5/15/12 through 5/19/12. The Medication Administration Record for May 2012 indicated on 5/14/12, the resident's pain medication, Norco 5/325 (hydrocodone/acetaminophen - narcotic/analgesic pain medication] was changed from administration as needed to 4 times daily. On 6/19/12 at 8:30 p.m., review at the websitehttp://packageinserts.bms.com/pi/pi_coumadin.pdf included, but was not limited to, the following from the package insert for Coumadin: "...Warning: Bleeding Risk: Coumadin can cause			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	major or fatal bleeding; Perform regular monitoring of INR in all treated patients; Drugs, dietary changes, and other factors affect INR levels achieved with Coumadin therapy....Drug Interactions: ...Drugs that increase bleeding risk: Closely monitor patients receiving any such drug (e.g. ...antiplatelet agents...); Antibiotics and antifungals: Closely monitor INR when initiating or stopping an antibiotic or antifungal course of therapy...." Review of the Geriatric Drug Handbook, 12th edition, indicated in the Drug Interactions Substrate for Warfarin (Coumadin), "Acetaminophen: May enhance the anticoagulant effect of warfarin. Most likely to occur with daily acetaminophen doses >1.3 g for > 1 week." Lab results for a Protime/INR for a blood specimen collected and reported 5/10/12 indicated: "Protime 19.7 H [high]" with Normal Range of 9.5 - 11.8 seconds and "INR 1.9 H" with 0.9 - 1.1 for the Normal Range. The report indicated, "Standard			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Anticoagulant: 2.0-3.0 INR" and "Aggressive Anticoagulant: 2.5 - 3.5 INR." Handwritten on the lab was "Coumadin 5 mg 1 po [by mouth] 4:00 p.m. daily." A stamp mark indicating "Faxed" was on the report, with the date of 5/10/12 and initials handwritten in a blank on the stamp mark. No notation on the lab report indicated the physician had reviewed the report. Nurse's Notes for 5/10/12 and 5/11/12 lacked documentation of follow-up with the physician related to the PT/INR report. The "History and Physical" note by the resident's attending physician, dated with date of service, dictation date, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	received date of 5/11/12, included, but was not limited to, "...Past medical history: ...Chronic Anti-coagulation...MAR [Medication Administration Record, labs, and hospital records have been reviewed there are no acute findings....Assessment and Plan...At this time, we will make no changes to the patient's current medication regimen with the exception of adding a PRN [as needed] pain medication. He does plan on returning home soon." During interview on 6/19/12 at 9:15 a.m., the Director of Nursing indicated the physician "would have seen that lab [dated 5/10/12]," and "did not change any orders" for the medication dose and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	further monitoring o PT/INR related to the recently increased dose o Coumadin. The Interdisciplinary Plan of Care, dated 5/18/12, for "Anticoagulation" indicated, "Resident is at risk for abnormal bleeding or hemorrhage because of anticoagulant usage." Goals were, "Resident will be free from signs and symptoms of abnormal bleeding through the next review date," and "Resident's PT and INF [sic] will be maintained within therapeutic range, as determined by their physician through the next review date." Approaches included, but were not limited to, "Schedule lab test as ordered by the physician to monitor coagulation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	factors - report results to physician." During interview on 6/18/12 at 3:40 p.m., the Assistant Director of Nursing (ADON) provided a copy of her Lab Tracking Log. She indicated she used the log to ensure all ordered labs were completed and reported to the physician. She indicated the log showed with check marks that on 5/10/12, Resident C's lab specimen for PT/INR was picked up, results received, and the physician was notified. In the column for "Orders" was handwritten "NO," and the initials of the ADON were in the column for "Comments." The ADON indicated she usually talks to the physician's nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	practitioner about labs, and she indicated no note was in the clinical record to indicate contact with the physician about the PT/INR for 5/10/12. The ADON indicated no orders were received related to further monitoring of the resident's PT/INR. During interview at this same time, the Director of Nursing (DON) in regard to monitoring labs for residents on Coumadin, "We have to draw PT/INR when the physician orders it." On 5/20/12 at 9:08 a.m., a physician's order indicated, "Send to [initials of local hospital] for eval [evaluation]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Emergency Department report, dated 5/20/12, indicated, "History of Present Illness: The patient...complains of rectal bleeding and generalized weakness. He states it developed over the past 12 hours. He denies other complaints....Physical Exam: Rectal: The patient does have bright red blood per rectum....Emergency Room Course: The patient was typed and screened, also was given intravenous fluids and normal saline 500-milliliter bolus....He was given fresh frozen plasma 4 units IV [intravenous]. Disposition: The patient will be admitted to the hospital with diagnosis of rectal bleeding, Coumadin toxicity...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A lab report for PT/INR collected on 5/20/12 at 11:15 a.m. indicated, "PT Range 9.3-11.7 sec: H >120 INR >13.1." A footnote indicated the result was called to the emergency room physician on 5/20/12 at 11:37 a.m. The hospital History and Physical, dated 5/20/12, indicated, "Reason for Admission: Severe nausea, vomiting, bilious emesis, loose stools, abdominal pain in the epigastrium, Hematemesis and hematochezia earlier today. Problem List: Acute Coumadin toxicity, iatrogenic, recently started on Coumadin therapy in the hospital during [sic] his last admission			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	after consulting with Cardiology....History of Present Illness: ...The patient was discharged to the nursing home for continuation of Coumadin therapy. Apparently, but I am not sure about this, the patient has not had a recent PT and INR until today when he complained of some Hematemesis. He also had some bright red blood per rectum. The nursing home room [sic], because of nausea and vomiting, and other complaints, decided to send him to the emergency room for further evaluation, from where he is admitted to our service for further management....Assessment:....now coming in with coagulopathy of 13, although he has been on antibiotics,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	which may have led to part of this problem....My recommendations will be to hold off on Coumadin therapy for now. We will reverse the coagulopathy with fresh frozen plasma. He has received 4 units already. We will give some vitamin K subcutaneously now. We will ask Gastroenterology to see him. We will ask Cardiology to address the issue of Coumadin therapy resumption...." 2. The clinical record for Resident H was reviewed 6/19/12 at 11:20 a.m. The record indicated the resident was admitted on 5/3/12 with diagnoses including, but not limited to, fracture of right hip.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician's orders, dated 5/3/12, included, but were not limited to, "Coumadin 7 mg 1 po [by mouth] qd [daily] X [times] 1 wk [week]" and "PT/INR daily." A lab report, dated 5/4/12, indicated, Protime of 20 - high (normal range 9.5 - 11.8) and INR 2.0 - high (normal range 0.9 - 1.1). A handwritten notation on the lab report form, signed by the Nurse Practitioner on 5/5/12, indicated, "1. Cont [continue] same dose. 2. Re [check mark] 2 weeks 5/16/12 fax results to office." A physician's order, dated 5/5/12 (untimed), indicated, "T.O. [telephone order] [name of Nurse Practitioner] Re			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[check mark] PT/INR 5/16/12 continue same dose (7 mg)." A lab report, dated 5/5/12, indicated, Protime 25.5 - high (reference range - 10.0 - 25.0) and INR 2.3 - high (reference range 0.9 - 1.1). An unsigned, handwritten notation on the report indicated, "N.O. [new order] Re [check mark] PT/INR 5/16/12 cont current dose 5/5/12." A stamp mark indicating "Faxed" was on the report, with the date of 5/5/12. No initials indicated who had faxed the report. Documentation on the lab report and in the nurse's notes failed to indicate the physician's order dated 5/5/12 was confirmed after the PT/INR report on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/5/12. Nurse's Notes for 5/12/12 at 6:00 p.m., indicated, "New orders received et [and] noted to draw INR today when lab comes. Coumadin 7mg cont [continues] @ 4 p.m. daily...." Documentation in the Nurse's Notes failed to indicate information related to the reason for the PT/INR at this time. Nurse's Notes indicated the lab was drawn on 5/12/12 at 7:00 p.m. During interview on 6/19/12 at 2:45 p.m., the DON indicated the record did not indicate why the PT/INR was ordered on the evening of 6/12/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A lab report, dated 5/12/12 at 11:51 p.m., indicated, Protime 45.1 - high (reference range 10.0 - 12.5) and INR 4.1 - critical (reference range 0.9 - 1.1). A footnote for the INR 4.1 indicated, "Critical value(s) called to, repeated, and verified by [name] @ 2336 [11:36 p.m.] on 5/12/12 by [identifier number]" A handwritten notation on the lab report indicated, "Hold Coumadin X 2 Check INR on day 3 as per [name of Nurse Practitioner] 5/13/12 12:45 a.m." A physician's telephone order, dated 5/13/12 at 12:45 a.m., indicated, "Hold Coumadin X 2 days due to critical INR level. Recheck INR on days 5/15/12."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Medication Administration Record for May 2012 indicated next to the entry for "Coumadin 7 mg 1 po qd:" the nurse's initials for the dose for 5/12/12 was circled, but no documentation on the reverse of the form indicated information related to the medication on that date. A box was drawn around the dates of 5/13 and 5/14/12, with the word "hold" handwritten in. Documentation indicated the resident received the 7 mg dose from 5/16 through 5/31/12. Lab reports and Nurse's Notes failed to indicate the PT/INR was checked as ordered on 5/15/12 (based on the order of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING _____ B. WING 00	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/13/12) and 5/16/12 (based on the order of 5/5/12). Undated and handwritten on the Medication Administration Record for May 2012 was the following entry; however, no physician's order was documented for this: "PT/INR 3 days Coumadin on hold 5/15 & 5/16, re [check mark] 5/17." During interview on 6/19/12 at 3:55 p.m., the Assistant Director of Nursing indicated the PT/INR was not drawn on 5/15 and 5/16/12. A lab report, dated 5/17/12, indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Protime 26.8 - high (normal range 9.5 - 11.8) and INR 2.6 - high (0.9 - 1.1). An unsigned, handwritten on the report was, "Restarted Coumadin 7 mg on 5/15 Coumadin held 5/12 - 5/13 - 5/14." Documentation in the Nurse's Notes failed to indicate follow-up with the physician related to the lab. An unsigned, handwritten notation on the lower right corner of the report indicated, "Noted 5/24/12." A handwritten notation, signed by the Nurse Practitioner on 5/25/12, indicated, "1. Cont [continue] same dose. 2. Re [check mark] one month." A physician's order, dated 5/24/12, indicated, "Repeat PT/INR on 6/17/12."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nurse's Notes for 6/4/12 at 6:00 p.m., indicated, "NP [Nurse Practitioner] here [symbol for with] n.o. received and noted." A physician's order, dated 6/4/12, indicated to recheck the INR on 6/5/12. A lab report, dated 6/5/12, indicated Protime - 64.5 - high and INR 6.3 - critical high. A physician's order, dated 6/5/12, indicated to hold the Coumadin on 6/5 and 6/6/12, and recheck the PT/INR on 6/7/12. A lab report, dated 6/7/12, indicated Protime 66.4 - high and INR 6.5 - critical high. A physician's order, dated 6/7/12, indicated to hold the Coumadin on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/7 and 6/8/12 related to increased PT/INR and recheck the PT/INR on 6/9/12. A lab report, dated 6/9/12, indicated Protime 18.5 - high and INR 1.8. A physician's order, dated 6/10/12, indicated, "D/C [discontinue] previous Coumadin 7 mg; Start Coumadin 5 mg po q [every] daily. Recheck PT/INR in 3 days." A lab report, dated 6/13/12, indicated Protime 12.0 - high and INR 1.2 - high. Unsigned, handwritten notations on the lab report indicated, "Coumadin dc'd [discontinued] on 6/10/12" and "Cont			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[continue] coumadin 5 mg q day." Documentation in physician's orders, nurse's notes, and on the lab reports failed to indicate a physician's order had been received for further monitoring of the resident's PT/INR. During interview on 6/19/12 (Tuesday) at 2:45 p.m. in regard to the facility's plan for further monitoring of the resident's PT/INR, since the Coumadin dose had been changed, the DON indicated the facility would follow the doctor's orders. When interviewed as to when the physician would visit Resident H again to possibly write orders, the DON indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Nurse Practitioner visits the facility on Mondays, but was not present on Monday, 6/18/12, due to illness. She indicated the Nurse Practitioner would probably not visit again until the following Monday, 6/25/12. 3.1-48(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE